EXHIBIT 7
DATE 2-19-07
HB 605

ROBERT CALDWELL, M.D.

I am writing in support of HB 605, which will further define the duties and qualifications of a Medical Assistant. I am a Helena physician with 27 years in practice, 15 years in Montana.

I believe that enacting HB605 would help ensure the public safety. It would require that, like plumbers and electricians, Medical Assistants complete a designated program of study and be certified as competent. It would limit them to designated procedures with on-site physician supervision, rather than allowing the full range of medical practice at a remote location if the physician chose to allow this.

Under the existing rule, there is no requirement that a Medical Assistant have completed any specific training, or even be literate. A physician or podiatrist could, in theory, show a Medical Assistant how to perform a medical procedure and allow the assistant to perform it at a remote location with no real understanding of the potential risks and pitfalls involved. I understand that this is, in fact, being done and that Medical Assistants are performing such procedures as conscious sedation.

Many seemingly minor procedures, such as administering IV medication, starting an IV, or doing a lumbar puncture can be done correctly and many times over before a complication will occur. Complications will eventually occur, in spite of appropriate precautions. It is not clear to me how a Medical Assistant without any grounding in the theory or rationale of a procedure would figure out that something is going wrong, decide what is going wrong and figure out how to manage it.

To understand how this could occur, I invite your attention to the fact that medical students, interns, and residents are trained under a model of "see one, do one, teach one." This means that one is expected to learn a procedure by watching someone do it while he/she is explaining it, then try the procedure themselves, then be able to show someone else how to do it. As an intern, this is how I learned to do spinal taps. As an intern I once performed a thoracentesis (putting a needle between someone's ribs and withdrawing fluid) because I had heard it explained in class. In retrospect, even though the procedure went quite well, I probably should not have attempted it because I was not prepared to deal with the potential complications, such as a collapsed lung. With 20 years experience in practice, during my only attempt at conscious sedation, doing everything correctly, I watched the procedure go in a completely unexpected direction. I was attempting to do a rapid narcotics detox in the hospital on an otherwise healthy young patient. I administered a modest dose of a sedative and watched the patient become delirious and psychotic. I became quite concerned, and spent another couple of hours at the bedside making sure that she would be OK.

Unfortunately, without specific guidelines, I fear that this is exactly how some Medical Assistants will be trained, that is, shown how to do something then turned loose to do it, with far less training (8000 hours of medical education) than I had as an intern. I am concerned that those physicians with less that average critical thinking skills and who are the least systematic about managing risk, will also be the least systematic about training Medical Assistants and allow them the most latitude. This will allow the greatest potential to compound medical errors. A Medical Assistant without enough information cannot cope with unforeseen problems.

1125 MISSOULA AVE. SUITE B• HELENA, MT • 59601
PHONE: 495-1515• FAX: 495-1520

A patient expects to be able to trust their physician. They have a right to expect that the physician will approach their care with a certain standard of diligence and judgment and the background training to make that judgment meaningful. They have a right to expect that that anyone the physician allows to care for them is also appropriately trained. HB 605 will make a large step toward ensuring that this is the case.

Sincerely,

Robert Caldwell, MD